CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

CHAPTER II
TABLE OF CONTENTS

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PARTICIPATING SERVICES FACILITATOR

A participating consumer-directed (CD) services facilitator is an institution, facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed participation agreement with DMAS. Consumer-Directed Personal Attendant Care is a service offered through the Consumer-Directed Personal Attendant Services Waiver (C-DPAS Waiver).

Service coordination agencies provide supportive services designed to prevent or reduce inappropriate institutional care by assisting eligible individuals with the employer role of hiring, training, supervising, and firing the personal attendants who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of service coordination services. All providers contracting with Medicaid to provide services agree, as part of the provider participation agreement, to adhere to all the policies and procedures in this provider manual.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing DMAS for any services provided to Medicaid recipients. The provider, interested in becoming a Medicaid provider, must submit a letter to First Health Services - Provider Enrollment Unit (FHS-PEU) requesting a provider participation agreement. Requests will be screened to determine whether the applicant meets the basic requirements for participation. An application will be mailed to any interested party who meets the basic requirements for participation.

FHS-PEU will review the documentation from the provider that verifies provider qualifications. If the provider meets the qualifications as outlined in this chapter, FHS-PEU will send the provider notification that the application has been approved. The provider must maintain documentation (including relevant license, personnel records, etc.) that verifies the provider's qualifications for review by DMAS staff.

Upon receipt of the signed participation agreement and verification of approval, FHS-PEU returns a copy of the signed participation agreement to the provider and assigns a provider number. DMAS will not reimburse the provider for any services rendered prior to the assignment of this provider identification number (ID). This number must be used on all claims and correspondence submitted to the Medicaid Program.

If the provider wishes to open another agency or office in a different part of the State, the provider must obtain a new ID number for the new agency prior to initiating services in

that area. A provider may not bill DMAS for services provided at one agency branch using the ID number of another agency branch. Providers will have a different ID number for each type of service (Personal Care, Respite Care, etc.) provided.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

Providers may request participation agreement(s) by writing, calling, or faxing a request to:

First Health
VMAP-PEU
P.O. Box 26803
Richmond, VA 23261-6803

Phone: (804) 270-5105
Fax (804) 270-7027
Toll-free in state only 1-888-829-5373

PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. Currently, dissemination of this information is accomplished through the DMAS website, as well as, with regard to certain publications, by mailing such publications directly to providers, keyed to the provider number on the enrollment file. For publications that are mailed to providers, this means that each assigned provider receives program information. Since DMAS does not always know which provider groups have multiple offices or which groups use one central office, providers may receive multiple copies of such publications sent to the same location. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it to the First Health - Provider Enrollment Unit at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

(See the "Exhibits" section at the end of the chapter for a sample of the form.)

Copies of manuals, manual updates, and certain other publications are available on the DMAS website (www.dmas.state.va.us). If you do not have access to the Internet, please contact DMAS' mailing contractor, Commonwealth Martin, at 804-780-0076.

GENERAL REQUIREMENTS

All providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other activities specified by DMAS:

- Immediately notify FH-PEU, in writing, of any change in the information which the provider previously submitted to DMAS. This includes any change in provider status (location, mailing and payment addresses, administrative and nursing staff, etc.). Any change in an individual's condition or level of service delivery as outlined in the policies in this manual; should be directed to WVMI (the DMAS contractor effective April 2, 2001).

- Assure freedom of choice to individuals seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and included in the individual's plan of care, and participating in the Medicaid Program at the time the service or services were performed;

- Assure the individual's freedom to reject medical care and treatment;

- Accept referrals for services only when staff is available to initiate and perform the services on an ongoing basis;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to individuals in full compliance with Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.), as amended, which provides civil rights protections to persons with disabilities with respect to employment, public accommodations, state and local government services, and telecommunications;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Submit charges to DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept Medicaid payment from the first day of eligibility;

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an individual for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered.

  Example: If a third party payer reimburses $5 of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the individual, a spouse, or a responsible relative;

  A provider may not bill DMAS or an individual for broken or missed appointments.

- Use program-designated billing forms for the submission of charges;

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all personal care provider agency business is conducted.

  In general, such records shall be retained for a period of at least five (5) years from the last date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years;

- Policies regarding the retention of records shall apply even if the provider discontinues operation. DMAS must be notified in writing of the storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia;

- Furnish information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested. The Commonwealth's right of access to provider agencies and records shall survive any termination of this agreement;

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;

- Disclose all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals of Medicaid;

- If ownership of the provider changes, notify DMAS, WVMI and First Health – PEU within 15 days prior to the date of the change;

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding the individuals served. A provider shall disclose information in his or her possession only when the necessary information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public;

- Employ and supervise professionally trained staff meeting the requirements stated in this chapter and in state and federal laws and regulations; and

- Assure that no process of bankruptcy or financial insolvency has been adjudicated or is pending in state or federal court and agree to inform DMAS of any action instituted with respect to financial solvency.

Freedom of Choice

At the time individuals are approved for services, the nursing home pre-admission screening committee must inform the individual of available service CD coordination providers and (1) that they have the option of selecting their providers and (2) provide a list of CD services facilitators.

Advance Directives

At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding each individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, providers must:

- Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform individuals about the provider's policy on implementing advance directives;
- Document in the individual's medical record whether he or she has signed an advance directive;
- Not discriminate against an individual based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

PROVIDER PARTICIPATION STANDARDS

In addition to the above, to be enrolled as a Medicaid CD services facilitator and maintain provider status, a provider must meet the following special participation conditions:

Staffing Requirements

1. Consumer-Directed (CD) Services Facilitator Requirements

   The CD services facilitator provide ongoing supervision of the individual's Plan of Care. It is preferred that the CD services facilitator possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. In addition, the CD services facilitator must have two years of satisfactory experience in the human services field working with persons with severe disabilities or the elderly. The CD services facilitator must possess a combination of work experience and relevant education which indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the application form, found in supporting documentation, or observed during the interview. Observations during the interview must be

documented. The knowledge, skills, and abilities shall include, but are not necessarily limited to:

a. Knowledge of:

(1) Types of functional limitations and health problems that are common to different disability types and the aging process, as well as strategies to reduce limitations and health problems;

(2) Physical assistance typically required by people with severe physical disabilities or elderly persons, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(3) Equipment and environmental modifications that are commonly used and required by people with physical disabilities or elderly persons which reduce the need for human help and improve safety;

(4) Various long-term care program requirements, including nursing home and adult care residence placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance services;

(5) DMAS consumer-directed personal attendant services program requirements, as well as the administrative duties for which the individual will be responsible;

(6) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning;

(7) Interviewing techniques;

(8) The individual's right to make decisions about, direct the provisions of, and control his or her attendant care services, including hiring, training, managing, approving time sheets, and firing an attendant;

(9) The principles of human behavior and interpersonal relationships; and

(10) General principles of record documentation.

b. Skills in:

(1) Negotiating with individuals and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, and providing services to persons with severe disabilities or elderly persons; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have print impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively both orally and in writing; and

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds.

Documentation of a degree or license and previous satisfactory experience must be maintained in the provider's personnel file for review by DMAS staff. There must also be documentation of positive work history as evidenced by at least two satisfactory reference checks recorded in the CD services facilitator's personnel file.

If the CD services facilitator employed by the provider is not a registered nurse (RN), the provider must have registered nurse consulting services available, either by a staffing arrangement or through a contracted consulting arrangement. The RN consultant is to be available as needed to consult with individuals and CD services facilitator on issues related to the health needs of the individual. Any lapse in RN coverage must be reported immediately to

WVMI, CBC Review Section. A lapse in RN or qualified CD services facilitator availability may require that the CD services facilitator subcontract with another provider until appropriate staff can be hired. If the provider is unable to provide nursing services for a period of 30 days or service coordination services for a period of 60 days, individuals should be transferred by the CD services facilitator to another CD services facilitator and immediately notify WVMI.

2. Personal Attendant Requirements

It is the individual's responsibility to hire, train, supervise, and, if necessary, fire the personal attendant. Each attendant hired by the individual must be evaluated by the individual to ensure compliance with the minimum qualifications as required by DMAS. Basic qualifications for personal attendants include:

- Being 18 years of age or older;
- Possessing basic math, reading, and writing skills;
- Having the required skills to perform attendant care as specified in the individual's Plan of Care;
- Possessing a valid Social Security Number;
- Submitting to a criminal history record check. The personal attendant will not be compensated for services provided to the individual once the records check verifies the personal attendant has been convicted of any of the crimes that are described in 12 VAC 30-90-180. Personal attendants who have not been convicted of crimes will be reimbursed for care provided prior to the results of a criminal history record check;
- Receive annual CPR training, TB testing, and an annual flu immunization;
- Willingness to attend or receive training at the individual's request;
- Understanding and agreeing to comply with the consumer directed personal-attendant services program requirements; and
- Registration in a personal attendant registry, which will be maintained by CD services facilitators.

Attendants shall not be members of the individual's family. Family is defined as a parent or stepparent, spouse, children or stepchildren, siblings or stepsiblings, grandparents or stepgrandparents, or grandchildren or stepgrandchildren. In addition, anyone who has legal guardianship for the

individual shall also be prohibited from being an attendant under this program. A non-family live-in attendant may be the provider of Medicaid-funded consumer-directed personal attendant services for any competent individual.

The individual should verify information on the application form prior to hiring a personal attendant. It is important that the minimum qualifications be met by each attendant hired to ensure the health and safety of individuals. These qualifications must be documented by the individual and maintained by the CD services facilitator for review by DMAS staff.

CD services facilitators are not responsible for finding personal attendants for the individual. CD services facilitators are also not responsible for verifying personal attendant qualifications. This is the individual's responsibility.

Areas of Service

The provider applicant notes on the application what localities (cities and counties) the provider wishes to serve. The provider must be able to adequately staff and supervise staff in any locality served from the provider's office.

If the provider is unable to demonstrate that adequate staffing or supervision can be maintained from the CD services facilitator into any locality served by the provider, the provider has the option of opening a separate provider agency in that locality. The provider should submit a provider application for this separate office which, upon approval, will be issued a separate provider identification number and will be expected to maintain all files related to individuals served by the office and to bill for those individuals from the office.

A differential rate is established for CD services facilitators that are providing services to individuals residing in the Northern Virginia localities (defined in Chapter VI) to reflect the higher cost of operating in these localities (both higher capital and wage costs).

Business Office

The provider must operate from a business office which is staffed and provides accessible staff space, files, business telephones, and an address for the receipt of mail and forms.

Change of Ownership

When ownership of the provider agency changes, FH-PEU and WVMI must be notified within 15 calendar days of the effective date of the change. A new application with a notice of organizational structure, statements of financial solvency and service comparability, and full disclosure of all information required by this chapter relating to ownership and interest will be required.

PROVIDER IDENTIFICATION NUMBER

DMAS will assign a provider identification number upon receiving, approving, and signing a contract executed by the provider. The provider will be sent a copy of the contract and the assigned provider identification number. DMAS will not reimburse the provider for any services rendered prior to the effective date of this provider identification number and the receipt of this number in writing by the provider**.** The provider must use this number on all billing invoices and correspondence submitted to DMAS or WVMI.

INDIVIDUAL RIGHTS/RESPONSIBILITIES

The provider must have a written statement of individual rights which clearly states the responsibilities of both the CD services facilitator and the individual in the provision of care. This statement of individual rights must be signed by the individual and the provider representative at the time services are initiated. This statement must be maintained in the individual's file, and a copy must be given to the individual. The individual rights statement must include the following:

- An ongoing assessment of the personal attendant's performance by the individual with the provider offering supportive services to the individual as is expected to ensure the health, safety, and welfare of the individual;
- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;
- The provider's responsibility to render services according to acceptable standards of care;
- The individual's obligation for patient pay in the payment of services provided by the personal attendant;
- The provider's responsibility to make a good faith effort to provide support services to the individual and to notify the individual when the provider is unable to provide support services;
- The individual must inform the provider of his/her responsibility to have some planned back-up for times when the assigned personal attendant is unable to provide services and to identify which staff the individual should contact regarding schedule changes;
- The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the services rendered, and to routinely check with the individual about his/her satisfaction with the services being rendered; and

- The individual's responsibility to treat the provider's employees with respect and to communicate problems immediately to the appropriate provider staff.

The Individual's Rights/Responsibilities Statement MUST complete and include the following notification of the appropriate source for complaints:

"Department of Medical Assistance Services (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (CD services facilitator) at (provider phone).

If the CD services facilitator staff is unable or unwilling to help you resolve the problem, you may contact WVMI in writing or by phone at:

WVMI
Attn: CBC Review
6802 Paragon Place – Suite 410
Richmond, VA 23230
(804) 648-3159 – Richmond
(800) 299-9864 – Rest of State
(804) 648-6992 – Fax

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for disabled individuals in the provider's program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. By signing the check, the provider indicates compliance with Section 504 of the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the FH-PEU 30 days prior to the effective date. The address is:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

A copy of the notification must be sent to:

WVMI
Attn: CBC Review
6802 Paragon Place – Suite 410
Richmond, VA 23230
1-804 648-3159 – Richmond
1-800 299-9864 – Rest of State
1-804 648-6992 – Fax

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 2.2-4000 et seq. of the Code of Virginia) (the APA) and the State Plan for Medical Assistance provided for in § 32.1-325

of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions. State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, DMAS Director review, and Secretarial review. First, the state-operated provider will submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his or her designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he or she deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

EXHIBITS

TABLE OF CONTENTS

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Medical Assistance Program

Home and Community Based Care Services Participation Agreement
Consumer-Directed Service Coordinator

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS** (***REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS***)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this day of , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide services in accordance with the Provider Participation Standards published periodically by DMAS in the appropriate Provider Manual(s), after being fully certified by DMAS to provide such services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in the above referenced Provider Manual(s).**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794) no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in DMAS.**
3. **The provider agrees to keep such records as DMAS determines necessary. The provider will furnish DMAS on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized DMAS representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made under DMAS constitutes full payment on behalf of the recipient except for patient pay amounts determined by DSS, and the provider agrees not to submit additional charges to the recipient for services covered under DMAS. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a DMAS recipient for any service provided under DMAS is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to DMAS.**
7. **Payment by DMAS at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by DMAS, the provider shall reimburse DMAS upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by DMAS when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by DMAS for any reason shall be resolved through administrative proceedings conducted at the office of DMAS in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health Services' use *only*

Director, Division of Program Operations Date

IRS Name (required)

Mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-7027

For Provider of Services:

Original Signature of Provider Date

Title

_____City or _____County of

IRS Identification Number (Area Code) Telephone Number

Medicare Carrier and Vendor Number

First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105